Children's Emotional, Behavioral, and Developmental Well-Being: New Data and Tools for the Field

February 9, 2010
3:00 – 4:00 p.m. ET

Questions and Answers

Answered by Dr. Perrin:

Q: What is the panel's opinion of Dr. Buckley's (from Florida) book on curing autism with chelation therapy and IgG infusions?
A: *I'm not aware specifically of Dr. Buckley's approach or book. Like many other conditions where we are just beginning to gather good evidence for what works and what doesn't, autism has many suggestions for untested treatments of different kinds. These include chelation and IgG infusions, for which no current evidence indicates that they help children with their symptoms or conditions. Hopefully, the next several years will bring systematic evidence for what works, what doesn't, and what is harmful in treatments for autism.*

Q: How much of the higher diagnosis of autism among white race may be driven by high income parents seeking a diagnosis of autism versus mental retardation because they want specialized services (note recent study that noted cluster in Beverly Hills? I have family that work in special education services and anecdotally it seems to be happening.)
A: *There is no question that some substantial portion of the growth in the diagnosis of autism reflects increased awareness of both parents and providers about the condition and its diagnosis, as well as the recognition that having this diagnosis makes children eligible for certain services. Although there have not been careful studies of these differences by race, the recent paper by Kogan et al., in Pediatrics, noted that about 40% of children who had had a diagnosis of autism no longer had the diagnosis – and that was particularly true among African-American children. This finding might reflect the difficulties that African-American families face accessing services for their children.*

Q: How does the prevalence of autism in children compare to the prevalence of autism in adults?
A: *I have not seen good studies of the prevalence of autism among adults. There does seem to be evidence that younger children have higher prevalence rates than older children and adolescents – whether this represents a true increase in recent years or a restatement of children's diagnoses is unclear.*

Q: Can you discuss what you have found regarding the asthma epidemic and prematurity in contrast to the effect of an environmental factor like air quality? And have you looked into the possible interaction of environmental factors (ex:air quality) and prematurity on asthma incidence especially in urban communities and among those of lower socioeconomic status?
A*: If the question is whether prematurity, more common among poor households, interacts with air quality to lead to more asthma, then yes. Although air quality in most cases is not the major environmental player for children.*

Q: What percentage of the increase in diagnosis of ASD can be attributed to increases and change in diagnostic criteria?
A: *It's difficult to give an exact answer here; authorities who have studied the changing epidemiology of ASD come up with differing answers. In general, a large amount of the growth in diagnosis reflects relabeling (mainly of children with non-specific intellectual disability) or new diagnoses among children who had not been diagnosed in the past. Some, however, represents a true growth in the condition.*

Q: Dr Perrin, will you please refer participants to sources that address prevention for your areas of concern? Thanks.
A: *The key areas of prevention – at least for current knowledge – have to do with improving children's diets, increasing exercise and time outdoors, and diminishing media time. None of these are particularly novel (or easy), but much evidence supports the value of these three main changes in children's lives as a way to prevent asthma, obesity, and mental health conditions.*

Q: Do you consider juvenile Bipolar Disorder as related to Autism spectrum disorders?
A: *At the moment, I would say no – but we will see major changes in the thinking about bipolar disorder with the DSM-V and there is increasing evidence of co-occurrence of a number of mental health conditions in the families of children with ASD.*

Q: What are you impressions of long-term impact of dietary synthetic chemical adjuvants and additives in daily consumed food products on expressing specific chronic health conditions due to accumulated toxicity?
A: *Currently, we have very little evidence about specific additives. Some recent work in the Lancet has suggested certain red dyes as associated with ADHD, but even those data are preliminary. As a society, we encounter a huge number of new foods and additives and preservatives each year – most of these have had only limited testing about their safety – especially in any long-term use. I expect that the next decade will bring substantial new information about the potential toxic effects of a number of new materials encountered in the environment.*

Answered by Dr. Ghandour:

Q: The finding that being male is associated with a higher likelihood of being diagnosed with anxiety or depression is surprising given the higher rates of depression among females. Did you examine anxiety and depression at all separately to determine if there were gender differences?
A: *The finding that males had a higher adjusted odds of having ever been diagnosed with depression or anxiety, while in contrast to what we know about older girls being at increased risk for these symptoms, is probably best explained by the fact that boys are more likely to experience behavioral or conduct disorders. These types of conditions are frequently more disruptive for parents/families, resulting in greater contact with health care practitioners and diagnoses of both the original disruptive/conduct-related condition and comorbid depression or anxiety. I have not yet explored covariates for individual diagnoses, but am planning to do so.*

Q: Will there be a study involving ages 0-5?
A: *We originally wanted to include younger children in this study, but found that a significant proportion of the data for these children were missing for these particular indicators. As a result, we didn't feel comfortable with the estimates that were calculated. Future analyses could use other variables related to mental health variables related to mental health symptoms (rather than diagnosed conditions) that may yield more reliable estimates.*

Q: Does the study go into more detail in relation to Infant /Toddler Mental Health and how can we read this research?
A: *As noted above, we didn't feel comfortable with the estimates that were available for the youngest children given the high number of missing observations.*
In terms of "reading the research", we believe that the most important take-home message is that after adjusting for known covariates of mental health problems among children, significant state-level differences existed in both the odds of ever being diagnosed with depression or anxiety and the odds of receiving treatment in the past year if a child had ever been diagnosed with a behavioral or conduct-related condition. As noted in the last portion of the presentation, however, we believe that it is important to remember the context in which children receive diagnoses and parents report those conditions. Thus, a high prevalence of depression/anxiety may not necessarily mean that a greater proportion of kids are actually sicker in one state (though, they may be), but that the state may be doing a better job of identifying children with mental health conditions. We urge folks at the state-level to think about these data in their particular context of both child health and mental health care access since both impact a child's odds of having a diagnosed mental health condition.

Q: Did you do any comparisons between the National Survey of CSHCN and the National Survey of Child Health?
A: *A manuscript on internalizing symptoms (depressive and anxious symptomolgy) among CSHCN needs was recently released in Pediatrics (Ghandour RM, Kogan MD, Blumberg SJ, Perry DF. Prevalence and correlates of internalizing mental health symptoms among CSHCH. Pediatrics. 2010 Feb;125(2):e269-77. Epub 2010 Jan 18). The major difference is that the NS-CSHCN did not ask about diagnosed conditions – only parent report of children's mental health symptoms so the analyses are not directly comparable. Data are also available on behavioral symptoms (not discussed in the citation above); please feel free to contact me at rghandour@hrsa.gov if you are interested in these.*

Q: Is there a significant difference between children growing up in single families/ atypical families vs. typical families with emerging MH conditions?
A: *Bivariate analyses did show that a significantly smaller proportion children living in households with two parents (either biological, adoptive, or step) had ever been diagnosed with depression or anxiety compared to children living with single mothers or in other types of households. Similarly, a significantly smaller proportion children living in households with two parents (either biological or adoptive) had ever been diagnosed with a behavioral or conduct-related condition compared to children living in other types of households, including those in two-parent households where one parent was a step-parent. Because family-structure was highly correlated with other covariates included in the final multivariate analyses,*

however, we did not include it in these models. Therefore, it is not possible to say what the independent effect of this factor is on the odds of every being diagnosed with one of these conditions.

Q: Do the rates of Autism reflect the state profile of the behavior based problems or the depression and anxiety profile?
A: *Unfortunately, these analyses have not yet been conducted.*

Q: Did you do any screening for an FASD (in particular Alcohol Related Neurodevelompental disorder for these kids?
A: *Unfortunately, no questions on FASD were included on the NSCH.*

Q: In the studies cited, were the kids evaluated by psychologists or psychiatrists?
A: *The National Survey of Children's Health does not identify who specifically diagnosed the child. The data captured parents' response to three questions on whether a doctor or other health care provider ever told them that the child had: Depression; Anxiety problems; or Behavioral or conduct problems, such as Oppositional Defiant Disorder (ODD) or Conduct Disorder (CD).*

Answered by Dr. Foy:

Q : Are there medical home models of care that are incorporating mental health services?
A: *Yes. Many pediatric medical homes provide mental health services as an integral part of routine health supervision (well child care): anticipatory guidance about parenting effectively, stimulating language, and helping the child manage emotions and behavior; surveillance for behavioral health problems in the family and child; and developmental / behavioral screening to identify children with social-emotional symptoms or functional difficulties. (See Bright Futures guidelines.) The medical home is often the first place parents go to seek help with their child's behavior or learning problem. Primary care providers often provide mental health assessment, mental health treatment, coordination of mental health services with schools and human service agencies; and/or referral to community providers of these services. A growing number of primary care practices are incorporating a mental health professional (e.g., licensed clinical social worker, psychologist, marriage and family therapist, professional counselor). This arrangement increases accessibility of mental health services and decreases stigma for the family, while enhancing the range of services provided in the practice and the level of inter-disciplinary collaboration afforded the involved professionals. Business models include one in which a mental health provider organization "out-stations" an employee in the primary care practice; one in which an independent mental health professional establishes a practice within the primary care practice site; and one in which the primary care practice employs and fully integrates the mental health professional. (Williams et al, Clinical Pediatrics, July 2006).*

Q: With funding sources supporting the creation of silos that exist between agencies, how do we begin to collaborate to ensure that children receive services that come from a true system of care.
A: *Each agency must somehow commit time and resources to a common goal. Sometimes a specific project, event, or community need can get things started. Examples might include a health summit on child mental health, development of a process for inter-agency exchange of information, development of a community protocol defining roles and responsibilities for responding to psychiatric or social*

emergencies, or a response to the community's high school drop-out problem. Each agency can bring its concerns, perspective, resources, and experience to the conversation. In the process, relationships develop and, often, opportunities to blend funding streams and enhance coordination become apparent.

Q: Where is the best place for professionals (Public Health Nurse) who want to become Infant and early childhood mental health providers look for graduate education, etc..?
A: *My AAP colleagues know of major social emotional health promotion efforts in Alaska, Illinois, Kentucky, Michigan, and Ohio; if you happen to be in one of those states, perhaps you could track down folks involved with one of those programs and talk with them about how have been trained.*
Similarly, Project Launch states could be a resource: http://projectlaunch.promoteprevent.org/.
There are self study materials available from a number of sources, including CSEFEL at http://www.vanderbilt.edu/csefel/.
Child Care Health Consultants (CCHCs) receive some training on social emotional health (but not enough to become a licensed mental health provider). You can contact the National Training Institute for Child Care Health Consultants for a list of NTI graduates. These folks are trained to train CCHCs and may have some state-specific information regarding mental health consultation education.
Lastly, you could try contacting the person listed at the end of this Web page: http://gucchd.georgetown.edu/67637.html

Q: When you talked about the "monitor impact of change", you listed measures or data sources. Youth Risk Behavior Survey is listed. But, National Survey of Children's Health is not listed. Any reason or explanation that you can provide?
A: *The previous presenter had just discussed in depth the National Survey of Children's Health, which is obviously a superb resource. My list was intended to suggest data sources that might provide additional insights from the community and regional levels.*

Q: What kind of community supports and anticipatory guidance is available for young adults with mental health issues would be most important to provide?
A: *Young people with severely-impairing mental health disorders often require a great deal of support in reaching their educational goals, finding employment and housing, maintaining interpersonal relationships, living independently, transitioning from their pediatric sources of health care to adult providers, and finding health insurance. Ideally, each healthcare provider would begin to address these transition issues early in the course of the young person's illness; and, ideally, each community would have resources to assist youth with mental illnesses achieve recovery and independence. Programs involving trained peer specialists—people who have successfully navigated this process for themselves or family members—show great promise in supporting young people through this process.*

General/Unassigned:

Q: What are your thoughts about SPECT scans for diagnosis of children's health problems?
A:

Q: Please repeat the PDQ---strengths and ? For 4 year old to ? [NOTE FROM GRETCHEN: my apologies that I can't tell which presentation this refers to]
A:

Q: What would you say about the impact of environment on (especially a young child's "symptoms") actually showing as a result of environmental factors such as violence, lack of healthy attachments, etc. For example environmental factors may at times result in the same symptomology for example of ADHD or an anxiety disorder and given the young age of a child, it is this environment that has the bigger impact which may result in those symptoms vs. a sole or primary biological basis. Some of the interventions used effectively for interventing with the fully accurately diagnosed disorder. In other words for young children intervening (not with medication) prior to diagnosis may actually prevent the full onset of a disorder.
A:

Q: Can you comment on any work being done in improving family home visiting programs to move towards more evidence based programs (with early intervention and prevention)?
A:

Q: How might we gain access to the pediatric resource guide that was referred to? [NOTE FROM GRETCHEN: my apologies that I can't tell which presentation this refers to.]
A:

Q: It would be worth recognizing that developmental-behavioral pediatricians are natural allies in preventive and treatment of mental health and developmental disorders. [NOTE FROM GRETCHEN: I realize this isn't a question, but it might be worth saying whether you agree, and why.]

Q: I know this presentation is related to children. However, is there much discuss regarding infant mental health and the provision of care?
A:

Q: Cultural appropriateness, for new immigrant/refugee communities? What are the possible avenues when we lack MH services overall. [NOTE FROM GRETCHEN: my apologies that I can't tell which presentation this refers to]
A:

Q: You have not mentioned the Adverse Childhood Experiences Study, yet that might be the single most important reason why childhood treatment should be funded in order to prevent adult disease. Any comments?
A:

Q : Do we know whether there's been any increase in child maltreatment (abuse and/or neglect) related to the increase in children's chronic disease prevalence, especially mental illness?
A:

Q: Are there any plans to address the state level disparities to get treatment for these children?
A:

Q: The state of Hawaii is proposing to make its early intervention entry requirements more restrictive, they are taking comments. Can I get a shortened resource to refer to your recommendation for early intervention which ties EI to other health outcomes?

Answered by Moderator:

Q: What is SCHIP?
A: It is the "State Children's Health Insurance Program", now known simply as CHIP. It is an insurance program that targets uninsured children and pregnant women in families with incomes too high to qualify for most state Medicaid programs, but often too low to afford private coverage. Within Federal guidelines, each State determines the design of its individual CHIP program, including eligibility parameters, benefit packages, payment levels for coverage, and administrative procedures.

About the MCHIRC

The Maternal and Child Health Information Resource Center (MCHIRC) is dedicated to the goal of helping MCH practitioners on the Federal, State, and local levels to improve their capacity to gather, analyze, and use data for planning and policymaking.

The MCHIRC is funded by the Maternal and Child Health Bureau's Office of Data and Program Development under the supervision of Gopal Singh, Ph.D. The Project Director is Renee Schwalberg, MPH.

This question and answer sheet was created by moderator Gretchen Noonan and is available online at:

http://www.mchb.hrsa.gov/mchirc/dataspeak/events/2010/0209/archive/QandA.html

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